MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03093 (crossed out) 03085

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 3yrs.10mo.11days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Perry Point Veterans Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residance bafora admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Barbara — Middle: Unger — Last: Austin

4. DATE OF DEATH: Month: 3 — Day: 6 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1-27-72

9. AGE (In years last birthday): 90 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse

10b. KIND OF BUSINESS OR INDUSTRY: Nursing

11. BIRTHPLACE (County & State, or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Mr. Charles Unger

14. MOTHER'S MAIDEN NAME: Marie Deis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or detes of service): Spanish American War

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), end (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Multiple pulmonary infarcts right lung — INTERVAL BETWEEN ONSET AND DEATH: 4-5 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Bronchopneumonia bilateral severe — 6-10 days

DUE TO (c): Arteriosclerosis generalized — unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic heart disease

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: VA 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that [illegible] attended the deceased from April 23, 1958, to March 6, 1962 [illegible] and that death occured at 3:20pm from the causes and on the date stated above.

22a. SIGNATURE: A. L. Mooney M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 3-7-62

22c. PHYSICIAN'S NAME (Type): A. L. MOONEY

22d. ADDRESS: Asst. Clinical Pathologist, VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Spacify): Burial

23b. DATE THEREOF: 3/9/62

23c. NAME OF CEMETERY OR CREMATORY: Cherry Hill

23d. LOCATION (City, town or county) (State): Elkton, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks — ADDRESS: Hicks Funeral Home, Elkton, Maryland

25a. REC'D BY REGISTRAR DATE: MAR 14 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

(M)

1

M

03094

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03086

1. PLACE OF DEATH
- a. COUNTY: Cecil — MARYLAND
- b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Perry Point
- c. LENGTH OF STAY IN 1b: 10yrs6mo,15days
- d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
- a. STATE: Pennsylvania
- b. COUNTY: Cumberland
- c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shippensburg
- d. STREET ADDRESS: 117 N. Penn Street
- e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

75 x 3

50

3. NAME OF DECEASED (Type or print): First LYDA, Middle J., Last BAILY

4. DATE OF DEATH: Month March, Day 14, Year 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-27-87

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Pittsburgh, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: H. H. Hyland

14. MOTHER'S MAIDEN NAME: Susan A. Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW-I

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelitis, acute, bilateral

600.0

DUE TO (b)

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic heart disease with decompensation

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

0

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that VA XXXXXXXXXX) attended the deceased from August 27, 1951, to March 14, 1962XXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, and that death occured at 8:50am M. from the causes and on the date stated above.

22a. SIGNATURE: S Goldgraben M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 3-14-62

22c. PHYSICIAN'S NAME (Type): S. GOLDGRABEN

22d. ADDRESS: Chief, Medical Service, VAH, Perry Poiht, Md.

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-17-1962

23c. NAME OF CEMETERY OR CREMATORY: Unionville

23d. LOCATION (City, town or county) (State): Kennett Square, Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: Lee A. Patterson & Son — ADDRESS: LEE A. PATTERSON & SON, Perryville, Md.

25a. REC'D BY REGISTRAR DATE MAR 16 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL/ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

Item 20 Film 312 5-3-62 [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03095 — 04439

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Elkton
   d. STREET ADDRESS: R.D.1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First ~~Butler~~ Middle Toni Marie Last Butler

4. **DATE OF DEATH**: Month March, Day 28, Yr 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 25, 1962

9. AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months 2, Days — IF UNDER 24 HRS.: Hours —, Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -----

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter E. Butler

14. MOTHER'S MAIDEN NAME: Marguerite Russell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Walter E. Butler, Elkton, Md. R.D.1

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
- DUE TO (b) Aspiration of Vomitus — 10 minutes
- DUE TO (c) 921.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Spontaneous vomiting after given vitamin drops & aspiration of same (Accident)

20c. TIME OF INJURY Hour a.m. — p.m. —, Month, Day, Year: Mar. 28 62

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Elkton (County) Cecil (State) Md.

21. **I certify** that (I) (this hospital), attended the deceased from 1/26, 1962, to 3/28, 1962, that (I) (we) last saw the deceased alive on 3/28, 1962, and that death occured at 11:35 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Joseph G. Lanzi, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/28/62

22c. PHYSICIAN'S NAME (Type): Joseph G. Lanzi

22d. ADDRESS: 205 W. Main St. Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/31/62

23c. NAME OF CEMETERY OR CREMATORY: Cherry Hill Cemetery

23d. LOCATION (City, town or county) Cherry Hill, Md. (State)

24. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks — ADDRESS: Elkton, Md.

25a. REC'D BY REGISTRAR DATE: MAR 19 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Thawley

2-002108

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03096 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03087

Item 2 Film 0310 4/2/62 mh

1. PLACE OF DEATH
a. COUNTY: Cecil
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural- Conowingo, Md
c. LENGTH OF STAY IN 1b: Native of Md.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Rt. 1 & 222 at North end of Conowingo Dam

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. ~~Anne Arundel~~ Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort Geo. G. Meade, U.S.Army Camp Brunswick
d. STREET ADDRESS: 10X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Joseph Middle Andrew Last Clark
4. DATE OF DEATH: Month 3 Day 24 Year 1962
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 18 1941
9. AGE (In years last birthday): 21 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S.Army
10b. KIND OF BUSINESS OR INDUSTRY: U.S.Army
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Joseph Daniel Clark
14. MOTHER'S MAIDEN NAME: No information

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give wer or dates of service): 6-12-59 to 3-24-62
16. SOCIAL SECURITY NO.: 219-34-5595
17. INFORMANT Address: Capt. Frederic L. Mundy, Co. Hq. & Hq. Co. USAGO Fort Geo. G. Meade

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Compound, comminuted fracture, right & left parietal bones with destruction of — Interval between onset and death: Immed.
DUE TO (b): underlying meninges and brain tissue
DUE TO (c):

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

823 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Riding in truck which went over wall of Conowingo Dam
20c. TIME OF INJURY: Hour 5:30 a.m. p.m. Month, Day, Year 3-24 1962
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rt.1 & 222
20f. (City or town) Conowingo (County) Cecil (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): R. C. Dodson MD — M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 3-24-62
Address (Street, city, town, or county): Rising Sun, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal & BURIAL
22b. DAT THEREOF: 3-28-62
22c. NAME OF CEMETERY OR CREMATORY: Park Heights Cemetery
22d. LOCATION (City, town, or country) (State): Brunswick, Maryland

23. FUNERAL DIRECTOR: Lee C. Patterson & Son
ADDRESS: Perryville, Md.
24a. REC'D BY REGISTRAR DATE: MAR 2 8 '62
24b. REGISTRAR'S SIGNATURE: Clarence S. Krause

No Information

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03097

CERTIFICATE OF DEATH

Reg. Dist. No. 03088

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 Elkton
d. STREET ADDRESS: 243 East High Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Jacob — Last: Congo

4. DATE OF DEATH: Month: March — Day: 5th — Year: 1962

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 7, 1932

9. AGE (In years last birthday): 29 yrs.
IF UNDER 1 YEAR: Months: 4 — Days: 26 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Congo

14. MOTHER'S MAIDEN NAME: Anna Brooks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): Korean

16. SOCIAL SECURITY NO.: 215-28-7763

INFORMANT Address: Anna Congo-243 High St., Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Dilatation of Heart — INTERVAL BETWEEN ONSET AND DEATH: 1-Day
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Chronic Myocarditis — 3- Years
DUE TO
(c): Pulmonary Edema — 2- Days

422.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized Edema 3- Years

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/28/ 19 55, to 3/5/ 19 62 that I last saw the deceased alive on 3/3/ 19 62, and that death accurred at 4:00 M, fram the causes and an the date stated abave.

ACTUAL SIGNATURE: James L Johnson M.D. — ADDRESS (Street, city or town, state): 245 East High Street — DATE SIGNED: 3/5/62

PHYSICIAN'S NAME (Type): James L. Johnson M.D. — Elkton Cecil Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/8/62

22c. NAME OF CEMETERY OR CREMATORY: Griffith Cem.

22d. LOCATION (City, town, or county) (State): Cedar Hill, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edw. R. Bell — ADDRESS: 909 Poplar St.

24a. REC'D BY REGISTRAR DATE: MAR 9 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03098

CERTIFICATE OF DEATH

Reg. Dist. No. 03089

1. PLACE OF DEATH
a. COUNTY CECIL — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY CECIL

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CALVERT

c. LENGTH OF STAY IN 1b 5-YRS

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL — NORTH EAST

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GRAYBEALS NURSING HOME

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First IDA Middle M Last CONLYN

4. DATE OF DEATH Month MARCH Day 28 Year 1962

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH JUNE 27, 1864

9. AGE (In years last birthday) 97 yrs.

IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) WILMINGTON, DEL.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME SAMUEL SHUSTER

14. MOTHER'S MAIDEN NAME MARGARET KEELY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

INFORMANT Address MRS ELEANOR RACINE, NORTH EAST, MD.

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH 3 yrs.

450.0

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1 0 1961, to 3/28 1962 that I last saw the deceased alive on 3/28 1962 and that death occurred at 11A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Neil Taylor M.D. ADDRESS (Street, city or town, state) Rising Sun, Md DATE SIGNED 3/29/62

PHYSICIAN'S NAME (Type) Neil Taylor MD Rising Sun, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF 4/2/1962

22c. NAME OF CEMETERY OR CREMATORY ST. JAMES CEMETARY

22d. LOCATION (City, town, or county) NEWPORT (State) DELAWARE

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ralph M Reed, Rising Sun, Md.

24a. REC'D BY REGISTRAR DATE APR 2 '62

24b. REGISTRAR'S SIGNATURE Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03099

CERTIFICATE OF DEATH

03090

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Susquehanna Ave.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
d. STREET ADDRESS: Susquehanna Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Willis — Middle: Marshall — Last: Gillespie

4. **DATE OF DEATH**: Month: March — Day: 22 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/15/97

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (County & State, or foreign country): Maryland, Cecil Co.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Joseph Gillespie

14. MOTHER'S MAIDEN NAME: Effie Boulden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes — WW-1

16. SOCIAL SECURITY NO.: 716-12-3079

17. **INFORMANT** Address: Helen C. Gillespie, Perryville, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cancer of lung, right — INTERVAL BETWEEN ONSET AND DEATH: 8 Months

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3-15, 1962, to 3-22, 1962 that (I) (we) last saw the deceased alive on 3-22 19 62 and that death occured at 3 A.M., from the causes and on the date stated above.

22a. SIGNATURE: John D. Yun M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-22-62

22c. PHYSICIAN'S NAME (Type): JOHN D. YUN

22d. ADDRESS: PERRYVILLE, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Mar. 25, 1962

23c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery

23d. LOCATION (City, town or county) (State): RFD, Port Deposit, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Lee A. Patterson & Son, Perryville, Maryland

25a. REC'D BY REGISTRAR DATE: MAR 27 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03100

CERTIFICATE OF DEATH

04448

M

1. **PLACE OF DEATH**
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): EIKTON
c. LENGTH OF STAY IN 1b: 10 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Union Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 EIKTON
d. STREET ADDRESS: 116 Hollingsworth Manor
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

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3. **NAME OF DECEASED** (Type or print): First: David Middle: F. Last: Hollingsworth

4. **DATE OF DEATH**: Month: March Day: 18 Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec 9, 1903

9. AGE (In years last birthday): 58 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Produce

11. BIRTHPLACE (County & State, or foreign country): Chester Co, Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

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13. FATHER'S NAME: David F. Hollingsworth, SR

14. MOTHER'S MAIDEN NAME: Elizabeth Pyle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Address: Ann Marie Hollingsworth

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertesive cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO (b): with Consective Heart Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

443X

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Laenne's cirthosis with ascites

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June, 1962 to March 18 1962, that (I) (we) last saw the deceased alive on March 18 1962, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Tillman D. Johnson M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-21-62

22c. PHYSICIAN'S NAME (Type): Tillman D. Johnson MD

22d. ADDRESS: 123 Sincerly Ave Elkton Md

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/22/62

23c. NAME OF CEMETERY OR CREMATORY: Union Hill Cemetery

23d. LOCATION (City, town or county) (State): Kennett Square, Penna.

24 FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks ADDRESS: Elkton, Md.

25a. REC'D BY REGISTRAR DATE: APR 19 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03101 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03091

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any c is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 9/60

1. PLACE OF DEATH
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Earlville
   c. LENGTH OF STAY IN 1b: all life
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md.
   b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Earville
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John Middle Wesley Last Husfelt

4. DATE OF DEATH: Month 3 Day 31 Year 19 62

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1-11-1889

9. AGE (In years last birthday): 73 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming Retired

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Husfelt

14. MOTHER'S MAIDEN NAME: No information

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 220-07-6899

17. INFORMANT: Address: Sis Feaes Charlestown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion acute — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: R.C. Dodson M.D.

EXAMINER'S NAME (Type): R.C. Dodson

Address (Street, City or town, county): Rising Sun md.

DATE SIGNED: 4-1-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: April, 4, 1962

22c. NAME OF CEMETERY OR CREMATORY: Johntown Cemetery

22d. LOCATION (City, town, or country) (State): Earleville, Rural. Md.

23a. FUNERAL DIRECTOR: Edward Fellows

ADDRESS: Millington, Md.

24a. REC'D BY REGISTRAR DATE: APR 5 '62

24b. REGISTRAR'S SIGNATURE: Clarence E. Hines

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03102

CERTIFICATE OF DEATH

03092

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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2

1

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Kent
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Galena
d. STREET ADDRESS: 14X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Philip — Middle: Bernard — Last: Ireland

4. DATE OF DEATH: Month: March — Day: 31, — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 27, 1882

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Labor

10b. KIND OF BUSINESS OR INDUSTRY: Farming.

11. BIRTHPLACE (County & State, or foreign country): Galena, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph P. Ireland.

14. MOTHER'S MAIDEN NAME: Elizabeth Kennard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No.

16. SOCIAL SECURITY NO.: 214-34-6024

17. INFORMANT: Mrs. Frances Gillespie, Address: Galena, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Embolism massive — INTERVAL BETWEEN ONSET AND DEATH: 5 min

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): plebothrombosis rt leg. — ?

DUE TO (c): Carcinoma of rt kidney with regional metastases. — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility urethral stricture

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Mar 26, 19 62 to Mar 31, 19 62, that (I) (we) last saw the deceased alive on mar 31 19 62, and that death occured at 12:40 PM, from the causes and on the date stated above.

22a. SIGNATURE: Wallace Obenshain M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2 Apr 62

22c. PHYSICIAN'S NAME (Type): Wallace Obenshain, M.D.

22d. ADDRESS: Cecilton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 3, 1962

23c. NAME OF CEMETERY OR CREMATORY: Methodist Church Yard,

23d. LOCATION (City, town or county) (State): Galena, Kent Co; Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows

ADDRESS: Millington Md

25a. REC'D BY REGISTRAR DATE APR 4 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03103 Reg. Dist. No. 03093

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HOWARD Middle B. Last ISAACS

4. DATE OF DEATH: Month 3-24 Day Year 1962

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-25-1910

9. AGE (In years last birthday): 51 yrs. IF UNDER 1 YEAR: Months 11 Days 30 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laboror Trackman

10b. KIND OF BUSINESS OR INDUSTRY: B & O R.R.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Martin Isaacs

14. MOTHER'S MAIDEN NAME: Jane Biddle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705-09-7352

INFORMANT Address: Mrs Dorothy Honaker Port Deposit R.D. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardio-Vascular Failure — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Thrombotic Occlusion left coronary art. — 10 min.

DUE TO (c): Myocardial infarction — 10 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Sclerotic al coronary arteries. G.A.S., A.S.H.D.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-15, 1962, to 3-24, 1962 that I last saw the deceased alive on 3-23-62, 19 and that death occurred at 1.10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Luis M. Cuza M.D. ADDRESS (Street, city or town, stote): Cecil Ave. North East, Md. DATE SIGNED: 3-26-62

PHYSICIAN'S NAME (Type): Luis M. Cuza

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-27-1962

22c. NAME OF CEMETERY OR CREMATORY: Ebenezer

22d. LOCATION (City, town, or county) (State): Rising Sun Rural, Cecil Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R. Grant ADDRESS: Joseph R.Grant North East, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 28 '62

24b. REGISTRAR'S SIGNATURE: Charles L. Flinn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03104

CERTIFICATE OF DEATH

03094

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 12 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X North East
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Baby — Middle: — Last: Johnson

4. **DATE OF DEATH**: Month: March — Day: 2 — Year: 1962

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 1962

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 12 — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): Cecil County Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Corbin Johnson

14. MOTHER'S MAIDEN NAME: Modenna Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mother — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure (Atelectasis of Lung)
DUE TO (b): Prematurity
DUE TO (c):

762.5

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: — a.m. p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3/1, 1962 to 3/2, 1962 that (I) (we) last saw the deceased alive on 2 Am 1962, and that death occured at 3:54 A.M. from the causes and on the date stated above.

22a. SIGNATURE: James L. Johnson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/2/62

22c. PHYSICIAN'S NAME (Type): JAMES L. JOHNSON

22d. ADDRESS: 245 E. Highst, Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-3-62

23c. NAME OF CEMETERY OR CREMATORY: Methodist

23d. LOCATION (City, town or county) (State): North East Cecil Co Md

24 FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant

ADDRESS:

25a. REC'D BY REGISTRAR DATE: MAR 5 '62

25b. REGISTRAR'S SIGNATURE: Caroline S. Krause

2-031686

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03105 — 03095

CERTIFICATE OF DEATH

Item 23a Film 0309 3/22/62 jrb

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 60 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D.C.
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C. 47x·3
d. STREET ADDRESS: 118 46th St. S. E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
HENRY	EUGENE	JOHNSON	March	4,	19 62

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Negro		5-12-13	48 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Messenger	VA Office	Vandalia, Missouri	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Ed Johnson	Orpha King

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	WW II	Unknown	VA Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma Of Prostate With Metastases.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 2 To 3 Mon.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Uremia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that ☒ (this hospital) attended the deceased from January 3, 1962 to March 4, 1962, ~~xxxxxxxxxx~~ and that death occured at 12:25 AM from the causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22b. DATE SIGNED
Bernard S. Linn					3/4/62

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
BERNARD S. LINN, M.D.	VA HOSPITAL, PERRY POINT, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Buried	3-9-62	arlington cemetery	arlington va

24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. FILED BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Montgomery Bros	913 Flagler N.W.	3-9-62 MAR 14 '62	L.D. Montgomery No 54

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03106

CERTIFICATE OF DEATH

03096

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Elkton
c. LENGTH OF STAY IN 1b: 20 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Elkton RD #5
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First HARVEY — Middle L. — Last LEEDOM

4. DATE OF DEATH: Month Mar. — Day 22, — Year 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: Nov. 16, 1886

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Millright

10b. KIND OF BUSINESS OR INDUSTRY: Steel

11. BIRTHPLACE (County & State, or foreign country): Charlestown, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Levi L. Leedom

14. MOTHER'S MAIDEN NAME: Carrie Boyd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or detes of service): No

16. SOCIAL SECURITY NO.: 221-01-8871

17. INFORMANT Address: MRS. HARVEY L. LEEDON RD#5 ELKTON, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Years
420,0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] **OR CONTRIBUTING** [ ] **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour e.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-4-, 1962, to 3-22, 1962 that (I) (we) last saw the deceased alive on 3-8, 1962 and that death occured at 2:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE Tillman D. Johnson M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 3-22-62

22c. PHYSICIAN'S NAME (Type): Tillman D. Johnson M.D.

22d. ADDRESS: 123 Singerly Ave. Elkton, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-26-62

23c. NAME OF CEMETERY OR CREMATORY: Silverbrook Cem.

23d. LOCATION (City, town or county) (State): Wilmington, Del.

24 FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME

ADDRESS: Donald R. Pippin Elkton, Md

25a. REC'D BY REGISTRAR DATE: MAR 27 '62

25b. REGISTRAR'S SIGNATURE: Clinton L. Travers

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03107

CERTIFICATE OF DEATH

Reg. Dist. No. 03097

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cecilton Rural X
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Isabel — Middle: Clark — Last: Manlove

4. DATE OF DEATH: Month: March — Day: 27, — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 8, 1897

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Thomas Clark

14. MOTHER'S MAIDEN NAME: Laura Ellen Veach

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

INFORMANT: Miss, Emily M. Manlove, Address: Cecilton, Md. Rural

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): LEFT HEMIPLEGIA — INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): CEREBRAL HEMORRHAGE — 3 DAYS
DUE TO (c): CEREBRAL ARTERIOSCLEROSIS — 14 YEAR

331 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER):

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 2, 1962, to March 27, 1962, that I last saw the deceased alive on MARCH 27, 1962, and that death occurred at 1145 M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: Henry V. Davis M.D. — Chesapeake City Md. — 3/28/62

PHYSICIAN'S NAME (Type): HENRY V. DAVIS MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 30, 1962
22c. NAME OF CEMETERY OR CREMATORY: St. Stephen's Cemetery.
22d. LOCATION (City, town, or county): Earleville, Rural. (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Pullen — ADDRESS: Cecilton Md.

24a. REC'D BY REGISTRAR: DATE APR 2 '62
24b. REGISTRAR'S SIGNATURE: Clinton S. Travers

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03108

CERTIFICATE OF DEATH

03098

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 25yrs8mos19days

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Pennsylvania
b. COUNTY: Chester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parkesburg 75X-3
d. STREET ADDRESS: none
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Veterans Administration Hospital

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
FRANK		MILLER	March	9	1962

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	July 28, 1892	69 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Railroad	Dauphin County, Penna.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jacob Miller	Rose (?) Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes WW-1	Unknown	Hospital Records, VA Hospital, Perry Point, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Pulmonary Edema	1 Day
DUE TO (b)	Coronary Occlusion	1 Day
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Arteriosclerotic Heart Disease	Unknown

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
	VA 19					

21. **I certify** that ~~I~~ attended the deceased from June 18, 1936, to March 9, 1962 that ~~I~~ (we) last ~~saw~~ ~~March 9, 1962~~, and that death occured at 5:30PM, from the causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22b. DATE SIGNED
A.L. Mooney			3-9-62

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
A.L. MOONEY, M.D. Asst.Path.	VAH, Perry Point, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	3-14-62	Baltimore National	Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Pennington & Son, Havre de Grace, Md.		MAR 16 '62	Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03109

CERTIFICATE OF DEATH

03099

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 28Yrs.8 mo.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
1540-2
d. STREET ADDRESS: 10110 Georgia Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRY — Middle WEBSTER — Last MULLEN

4. DATE OF DEATH: Month March — Day 7 — Year 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-16-87

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10b. KIND OF BUSINESS OR INDUSTRY: -----

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wallace A. Mullen (deceased)

14. MOTHER'S MAIDEN NAME: Ida Harper (deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW-I

16. SOCIAL SECURITY NO.: -----

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of brain (cerebral vascular accident) — 3-4 weeks

332X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Cerebral thrombosis due to arteriosclerosis — 3-4 weeks

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Emphysema

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year: VA 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that XXXXXXXXXXX attended the deceased from June 21, 1933 to March 7, 1962 XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX and that death occured at 12:15 am M, from the causes and on the date stated above.

22a. SIGNATURE: A. L. Mooney M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 3-8-62

22c. PHYSICIAN'S NAME (Type): A. L. MOONEY

22d. ADDRESS: Asst. Clinical Pathologist, VAH, Perry Point, Md.

23a. ~~BURIAL~~, CREMATION, (REMOVAL) (Specify)

23b. DATE THEREOF: 3/12/62

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town or county) (State): Arlington, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: ~~Pennington & Son, Havre de Grace, Md.~~

25a. REC'D BY REGISTRAR DATE: MAR 16 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSP[illegible] ATTENDING PHYSICIAN: The law requires that the death certificate be executed [illegible]in 24 hours after death. Page 4 [illegible] be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03110

CERTIFICATE OF DEATH

03100

1. **PLACE OF DEATH**
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural North East
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Garrett — Middle: — Last: Oldis

4. **DATE OF DEATH**: Month: March — Day: 30 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept 17, 1871

9. AGE (In years last birthday): 90 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Trackman - Farmer

10b. KIND OF BUSINESS OR INDUSTRY: B & O R.R. Ret.

11. BIRTHPLACE (County & State, or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Benjamin Oldis

14. MOTHER'S MAIDEN NAME: Cornelia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Cecil County Welfare records — Address: Elkton, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardio Vascular Failure

DUE TO (b): Cardiac Decompensation

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): A. S. H. D.

420.0

INTERVAL BETWEEN ONSET AND DEATH: 5 min / 1 wk / Years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): G.A.S., Hypertension

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3-29, 1962 to 3-30, 1962 that (I) (we) last saw the deceased alive on 3-29 1962 and that death occured at 6:32 PM, from the causes and on the date stated above.

22a. SIGNATURE: Luis Cuza M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: April 2-1962

22c. PHYSICIAN'S NAME (Type): LUIS M. CUZA

22d. ADDRESS: Cecil Ave. North East, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-2-1962

23c. NAME OF CEMETERY OR CREMATORY: Bay View Methodist

23d. LOCATION (City, town or county) (State): North East R.D. Cecil Co., Md

24 FUNERAL DIRECTOR'S SIGNATURE: Joseph R. Grant

ADDRESS: Joseph R. Grant North East, Maryland

25a. REC'D BY REGISTRAR DATE: APR 3 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03111

CERTIFICATE OF DEATH

03101

Items 23a & b, Film G310 4/4/62 iwk

1. PLACE OF DEATH
a. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point,
c. LENGTH OF STAY IN 1b: 1 month 22 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bradshaw
d. STREET ADDRESS: Reynolds Road
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First OSCAR; Middle FRANK; Last RAY

4. DATE OF DEATH: Month March; Day 31; Year 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: December 22,1889

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter-retired

10b. KIND OF BUSINESS OR INDUSTRY: Painting

11. BIRTHPLACE (County & State, or foreign country): Baltimore County, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank Ray

14. MOTHER'S MAIDEN NAME: Lilly Jordan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): WW-I

16. SOCIAL SECURITY NO.: 220 20 7466

17. INFORMANT Address: Hospital Records, VAH., Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobar Pneumonia w/cavitation,rt lower & middle Lobe. — INTERVAL BETWEEN ONSET AND DEATH: 8 - 10 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Emphysema,bilateral,severe — Unknown
DUE TO (c):

527.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis,generalized, moderately severe.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I (this hospital) attended the deceased from February 9, 19 62 to March 31, 19 62 that I (we) last saw the deceased alive on March 31, 19 62, and that death occured at 8:AM, from the causes and on the date stated above.

22a. SIGNATURE: J. L. Garey M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 3-31-62
22c. PHYSICIAN'S NAME (Type): J. L. GAREY, M.D. Clinical Pathologist
22d. ADDRESS: VAH., Perry Point, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 4/3/62 3-31-62
23c. NAME OF CEMETERY OR CREMATORY: Mt Christian Church
23d. LOCATION (City, town or county) (State): Joppa, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Lassahn Funeral Home
ADDRESS: 7401 BelAir Rd., Baltimore 6, Md.

25a. REC'D BY REGISTRAR DATE APR 4 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03112

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03102

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9/60

1. PLACE OF DEATH
   a. COUNTY: Cecil
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun, Rural
   c. LENGTH OF STAY IN 1b: MARYLAND
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md.
   b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit Rural
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Timothy Middle: Roger Last: Stroud

4. DATE OF DEATH: Month: 3 Day: 13 Year: 19 62

5. SEX: M.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/2/1962

9. AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months 2 Days 10 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown ~~X~~ Foster Father Roger C. Stroud

14. MOTHER'S MAIDEN NAME: Unknown Foster Mother Frances A. Steele

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Roger C. Stroud Address: Port Deposit Md. R.D

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound, comminuted fracture, left parietal and temporal bones with extensive

DUE TO (b) damage to and loss of brain tissue

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Immediate

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Auto Accident

20c. TIME OF INJURY Month, Day, Year: Hour 6:40 p.m. 3-13-62

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 273

20f. (City or town) (County) (State): Cecil Co. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R.C. Dodson M.D.

EXAMINER'S NAME (Type): R. C. DODSON M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

Address (Street, city, town, or county): Rising Sun, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/15/62

22c. NAME OF CEMETERY OR CREMATORY: West Nottingham Cem.

22d. LOCATION (City, town, or country) (State): Colora Md. Rural

23. FUNERAL DIRECTOR: Vernon E. Mueller ADDRESS: Rising Sun, Md.

24a. REC'D BY REGISTRAR DATE: MAR 16 '62

24b. REGISTRAR'S SIGNATURE: Evelyn S. Kruse

2183

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03113 (crossed out) 03103

1

M

50

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2

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 7/61

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE: North Carolina — b. COUNTY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Perry Point — c. LENGTH OF STAY IN 1b: 14yrs.5mo.21days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Charlotte — 70 x-3
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Veterans Administration Hospital	d. STREET ADDRESS: 135½ S. Tyron — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
ALICE	L.	SULLIVAN	March	31	1962

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White		12-31-88	73 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Nurse	Private	Massachusetts	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edward F. Sullivan (deceased)	Ellen (?) Sullivan (deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	WW-I	None	Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Bronchopneumonia, bilateral	7-10 days
420.0 DUE TO (b)	Arteriosclerotic heart disease	unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis generalized

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
	VA 19			

21. **I certify** that I attended the deceased from October 10, 1947, to March 31, 1962 and that death occured at 9:30 a.m. from the causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22b. DATE SIGNED
A. L. Mooney M.D.		4-2-62
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY	22d. ADDRESS Asst. Clinical Pathologist, VAH, Perry Point, Md.	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
REMOVAL	4/4/62	Arlington National	Arlington, Va.

24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Pennington & Son	Havre de Grace, Md.	APR 5 '62	Arthur E. Krauss

1

FOR STATE HEALTH DEPT.

M

X

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03114

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03104

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural North East
c. LENGTH OF STAY IN 1b: 16
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural North East
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carl — Middle: Victor — Last: Wennberg

4. DATE OF DEATH: Month: March — Day: 12 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 5, 1885

9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Stockholm, Sweden

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ---- Wennberg

14. MOTHER'S MAIDEN NAME: Anna (no information)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): --

16. SOCIAL SECURITY NO.: 097-05-7805

17. INFORMANT — Address: Mrs. Esther M. Wennberg, North East R.D., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH:
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): arteriolsclerotic heart disease
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour 8 a.m. / p.m. — Month, Day, Year: 3 12.62 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State): North East Cecil Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Wellington Clemens Jr. M.D.

EXAMINER'S NAME (Type): Wellington Clemens Jr. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 3/12/62

Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 3-15-62

22c. NAME OF CEMETERY OR CREMATORY: Silverbrook

22d. LOCATION (City, town, or country) (State): New Castle Wilmington, Delaware.

23. FUNERAL DIRECTOR: Joseph R. Grant — ADDRESS: Joseph R. Grant North East, Md.

24a. REC'D BY REGISTRAR — DATE: MAR 15 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Travis